Received: **Reported:**

IMPORTANT: Tests performed will be determined on the basis of information provided below.

VIRUS
EXAMINATIONS

State of Washington
Department of Health

DIVISION OF PUBLIC HEALTH LABORATORIES
1610 NE 150th St K 17-9
Shoreline, Washington 98155
(206) 361-2874
Please Use Black Ink

Lab. No.

Patient _____ Age _____ Sex _____
(last name) (first) DOB _____

Address _____ City _____
Date Spec. Obtained _____ Date Onset _____
Immunizations and Dates:

Type of specimen:
Blood/Serum _____
CSF _____
NP/Thr _____
Stool _____
Urine _____
Other _____

Chief Clinical Findings. (check system involved and list chief symptoms)
( ) Respiratory _____
( ) Central Nervous System _____
( ) Cutaneous Eruptions -- Location and Type _____
( ) Gastrointestinal _____
( ) Cardiovascular _____
( ) Other _____
Viral Agent to Test for: _____
Clinical Impression _____
Optimally, collect isolation specimen within 3 days of onset. Submit each specimen as soon as collected. Keep at refrigerator temperatures. 24 hour delivery is preferred.

Send Result to: _____
_____ Street
_____ Wash. _____ (zip code)
Area Code/Phone ( ) _____
County _____

Clinical data should be provided by the physician.

_____
Signature of physician

(DO NOT WRITE BELOW THIS LINE)

Laboratory Results:

SEROLOGIC TESTS				**VIRUS ISOLATION**
Antigen	Type Test	S1	S2	Agent and Result

Interpretation/Comments:

_____
_____
_____
_____ Test completed by
_____ Unit Head